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SUFFOLK, ss.

BOARD OF REGISTRATION
IN MEDICINE

ADJUDICATORY CASE No. 2006-021

In the Matter of

SUZANNE B. ROTHCHILD, M.D.

STATEMENT OF ALLEGATIONS

The Board of Registration in Medicine ("Board") has reason to believe that Suzanne B. Rothchild, M.D. ("Respondent") has provided substandard care to six patients in Board of Registration in Medicine docket numbers 03-233 and 04-121.

BACKGROUND INFORMATION

1. The Respondent was born on December 28, 1948 and graduated from the State University of New York ("SUNY") Downstate Medical Center in 1973.

2. The Respondent is board-certified in Obstetrics and Gynecology as well as Maternal and Fetal Medicine and has been licensed to practice medicine in Massachusetts under certificate of registration number 39314 since 1976.

3. The Respondent maintains a private practice in obstetrics and gynecology with admitting privileges at Winchester Hospital.

FACTUAL ALLEGATIONS

4. In December 2001, Hallmark Health System initiated concurrent monitoring of the Respondent's cases for one year for

timeliness of response, patient coverage, and appropriate documentation.

5. In January 2003, Winchester Hospital disciplined Respondent for inadequate investigative techniques to prove fetal well-being, leading to delay in delivery of a non-responsive infant on December 1, 2002.

6. Winchester Hospital required Respondent to obtain a consultation on obstetrical admissions and attend a course in fetal monitoring.

7. In February 2004, ProMutual Group imposed a Secondary Remedial Action against the Respondent that included a surcharge, practice restrictions, and limitation of her practice to one hospital only.

8. After the Secondary Remedial Action, Respondent surrendered her privileges at Hallmark Health System in April 2004.

PATIENT A

9. Patient A was a 33-year-old woman with her first pregnancy, admitted to Winchester Hospital in labor on December 23, 2000.

10. The Respondent assumed coverage and care for Patient A at 8 a.m. on December 24, 2000.

11. The Respondent performed a caesarian section at approximately 2:33 p.m. on December 24, 2000.

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12. Patient A's baby suffered meconium aspiration and an entrapped fetal head.

13. Patient A's baby could not be resuscitated and was pronounced dead.

14. The Respondent's care of Patient A was below the standard of care.

15. The Respondent failed to diagnose arrest of dilation in a timely manner.

16. The Respondent failed to diagnose arrest of descent in a timely manner.

17. The Respondent failed to recognize that fetal tachycardia with occasional variable decelerations and no reassuring accelerations on the fetal monitor strips were indicators of a non-reassuring fetal status.

18. The Respondent failed to intervene with delivery in a timely manner.

19. The Respondent failed to perform a caesarian section within a reasonable time.

PATIENT B

20. The Respondent cared for Patient B throughout her pregnancy.

21. Patient B was admitted to Winchester Hospital in early labor on December 1, 2002.

22. The Respondent cared for Patient B throughout her labor.

23. Patient B's fetal monitor showed persistent late decelerations.

24. Patient B's baby was non-responsive at birth and suffered severe meconium aspiration syndrome, requiring transfer to Children's Hospital for intervention.

25. The Respondent's care of Patient B was below the standard of care.

26. The Respondent failed to recognize and respond to a non-reassuring fetal monitor strip that was significant for persistent late decelerations.

27. The Respondent failed to appropriately assess for fetal well-being.

28. The Respondent failed to intervene and deliver the infant at the critical time.

PATIENT C

29. Patient C was a 30-year-old woman who was in her first pregnancy.

30. The Respondent was Patient C's physician through her pregnancy.

31. In July of 2002, at 19 weeks gestation, an ultrasound showed that Patient C's fetus had a two-vessel umbilical cord.

32. In July 2002 and September 2002, Patient C consulted with a Maternal Fetal Medicine physician at Winchester Hospital for evaluation.

33. The Maternal Fetal Medicine physician recommended close fetal surveillance during pregnancy and labor, as a two-vessel cord is associated with increased fetal morbidity and mortality.

34. At 37 weeks of pregnancy, the Respondent discovered that Patient C's fetus was in a breech position.

35. The Respondent attempted an external version of the fetus in her office, but was unsuccessful.

36. At 38 ½ weeks of pregnancy, Patient C's membranes spontaneously ruptured.

37. On presentation to Winchester Hospital on December 8, 2002, Patient C's fetus was still in a frank breech position.

38. The Respondent gave Patient C the option of a vaginal breech delivery.

39. The Respondent failed to advise Patient C of the increased risks associated with vaginal breech delivery of a fetus with a 2-vessel cord.

40. Patient C consented to have a vaginal breech delivery.

41. The Respondent gave Patient C medication to initiate labor.

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42. The Respondent inserted Cervadil into Patient C's cervix to initiate labor.

43. While laboring, Patient C suffered a cord prolapse and the Respondent performed an emergency cesarean section.

44. Patient C's baby was delivered with a cord pH of 6.89 and concerns for brain damage.

45. The Respondent's care of Patient C was substandard.

46. The Respondent attempted a version in her office instead of the operating room.

47. The Respondent failed to recognize the increased risk of a two-vessel cord to this infant.

48. The Respondent failed to intervene with a caesarean section within 30 minutes of Patient C's fetal monitor strip showing variable decelerations.

49. The Respondent failed to follow up on a missing Beta strep test and did not know Patient C's Beta strep status at the time of delivery.

PATIENT D

50. Patient D was a 16-year old woman with a past medical history was significant for depression, asthma, smoking, and drug use.

51. The Respondent cared for Patient D throughout her pregnancy and delivery.

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52. Patient D started her prenatal care at about 15 weeks of pregnancy.

53. A maternal screen of Patient D showed an increased risk for Down syndrome.

54. On May 13, 2003, Patient D presented in the Respondent's office in premature labor at 34-3/7 weeks gestation.

55. The Respondent admitted Patient D to the hospital and administered antibiotics and two doses of Terbutaline, to which Patient D did not respond.

56. Patient D's fetal monitor strips showed decreased long-term and short-term variability, and no reactivity.

57. Patient D's fetal heart rate was flat and exhibited late decelerations.

58. Patient D delivered an infant weighing 2,150 grams with Apgar scores of 5 and 8.

59. Patient D's baby was diagnosed with Respiratory Distress Syndrome, sepsis, Grade 2 IVH, and possible meningitis.

60. Patient D's baby required intubation.

61. The Respondent's care of Patient D was below the standard of care.

62. The Respondent failed to interpret the fetal monitor strips correctly and to intervene appropriately with a caesarean section.

PATIENT E

63. Patient E was admitted to the hospital in early labor on or about May 10, 2003.

64. Patient E was fully dilated by 3:00 a.m. on May 11, 2003.

65. Beginning at about 6 a.m., the fetal monitor showed more frequent variables, more prolonged variables, and some loss of variability.

66. The baseline fetal heart rate increased to 170 beats per minute, sometimes increasing to 190 beats per minute.

67. By about 9:10 a.m., the fetal monitor strip showed absent fetal heart variability and more severe and persistent variable decelerations.

68. Patient E's infant was delivered at 10:14 a.m. with cyanosis, muscle flaccidity, and no respiratory effort, with Apgars of 1 and 8.

69. The Respondent did not obtain a cord pH test.

70. Patient E's baby required chest compressions and positive pressure ventilation.

71. The Respondent's care of Patient E was below the standard of care.

72. The Respondent failed to recognize the significance of the fetal monitor showing decreasing variability, persistent variable decelerations, and a rising baseline rate.

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73. The Respondent failed to document a plan of care or decision-making when there were concerns about fetal status.

74. The Respondent failed to intervene to expedite delivery when there was a fetus at risk.

75. The Respondent failed to perform a cord pH despite an Apgar score of 1.

PATIENT F

76. Patient F was a 27-year old woman, who had delivered one child previously.

77. Patient F's first pregnancy had been complicated by gestational diabetes, positive Group B strep, urinary tract infection, and shoulder dystocia during delivery.

78. The Respondent cared for Patient F throughout this second pregnancy and delivery.

79. The Respondent did not request or obtain previous obstetrical records.

80. The Respondent failed to take an adequate medical history from Patient F.

81. Patient F came into the hospital in labor on or about April 9, 2000.

82. The Respondent augmented Patient F's labor with Pitocin.

83. The Respondent encountered a severe shoulder dystocia during delivery, leading to significant brachial plexus injury in the newborn.

84. The baby suffered significant permanent injury and disability as a result of the brachial plexus injury.

85. The Respondent's care of Patient F was below the standard of care.

86. The Respondent failed to note the history of a shoulder dystocia in Patient F's previous delivery and failed to request or obtain previous obstetrical records.

87. The Respondent failed to anticipate, manage, and diagnose a likely shoulder dystocia in Patient F.

88. The Respondent augmented Patient F's labor with Pitocin, which is contraindicated when there is a potential shoulder dystocia.

89. The Respondent failed to document performance of appropriate maneuvers to displace an impacted shoulder dystocia.

LEGAL BASIS FOR PROPOSED RELIEF

A. Pursuant to G.L. c. 112, §5(c) and 243 CMR 1.03(5)(a)3, the Board may discipline a physician upon proof satisfactory to a majority of the Board that said physician engaged in conduct which calls into question her competence to practice medicine, including but not limited to practicing medicine with

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gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions.

B. Pursuant to 243 CMR 1.03(5)(a) 17, the Board may discipline a physician upon proof satisfactory to a majority of the Board that said physician is guilty of malpractice within the meaning of M.G.L. c. 112, § 61.

C. Pursuant to 243 CMR 1.03(5)(a) 18, the Board may discipline a physician upon proof satisfactory to a majority of the Board that said physician has committed misconduct in the practice of medicine.

The Board has jurisdiction of this matter pursuant to G.L c. 112, §§ 5, 61 and 62. This proceeding will be conducted according to the provisions of G.L. c. 30A and 801 CMR 1.01 et seq.

NATURE OF RELIEF SOUGHT

The Board is authorized and empowered to order appropriate disciplinary action, which may include revocation or suspension of the Respondent's license to practice medicine. The Board may, in addition to or instead of revocation or suspension, order one or more of the following: admonishment, reprimand, censure, fine, the performance of uncompensated public service, a course of education or training, or other limitation on the Respondent's practice of medicine.

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ORDER

Wherefore, it is hereby ORDERED that the Respondent show cause why she should not be disciplined for the conduct described herein.

By the
Board of Registration in Medicine,

Date: April 12, 2006

Martin Crane, M.D.,
Chairman

Sent by certified mail on 4/14/06 by gmf